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Georgia's New Evidence Code in the World of Workers' Compensation

By Matthew D. Walker, Drew Eckl & Farnham, LLP

Georgia's evidence law was originally codified and published in 1863, and many of the original rules of evidence have remained unchanged since that time. However, on May 3, 2011, Gov. Nathan Deal signed House Bill 24 into law, creating new rules of evidence which will go into effect on Jan. 1, 2013.[1] With respect to workers' compensation hearings, O.C.G.A. §34-9-102(e) provides that "the rules of evidence pertaining to the trial of civil nonjury cases in the superior courts of Georgia shall be followed unless otherwise provided in [the Workers' Compensation Act.]" From that standpoint, the changes to the evidence code will also change workers' compensation litigation. The focus of this article is on a number of changes that will be of particular interest to workers' compensation attorneys and litigants.[2] For purposes of clarity, the evidence code in effect through Dec. 31, 2012, will be referred to as "the old rules," and the code in effect as of Jan. 1, 2013, will be referred to as "the new rules."

Hearsay Generally

Arguments over the admissibility of out-of-court statements are among the most frequent evidentiary issues in workers' compensation claims and in all litigation. The old rules deem hearsay "illegal evidence," and such evidence cannot sustain a verdict even if admitted without objection.[3] The new rules "legalize" hearsay evidence, and to the extent that there is no proper objection to hearsay, it is admissible and can support a finding or verdict.[4] The new rules still allow out-of-court statements made by a witness who is testifying at the hearing and is therefore available for cross-examination (subject to other objections, of course).[5]

The term "original evidence," used in the old rules to describe certain out-of-court statements offered as nonhearsay, is eliminated from the new rules. The new rules accomplish the same goal by simply proscribing only those out-of-court statements which are offered "to prove the truth of the matter asserted."[6] Similarly, the concept of admitting out-of-court statements made as part of an act or made contemporaneously with an event as part of the "res gestae" is also removed from the new rules. Instead, that concept is replaced with hearsay exceptions allowing contemporaneous statements, excited utterances, statements relating to the declarant's "then existing mental, emotional, or physical condition," and statements relating to the intent of the declarant.[7] Although some of these changes seem to be merely semantic, the new rules should make it easier to understand the arguments when hearsay objections arise.

Business Records Hearsay Exception

The old rules require a live witness to lay the foundation for the business records exception to hearsay.[8] The new rules allow for written certification to provide the necessary foundation in lieu of testimony, provided advance notice is given to opposing parties.[9] Additionally, whereas the old rules did not allow opinions into evidence through the business records exception, the new rules allow them.[10] These changes should ease the burden of introducing employment records from prior employers, and similar documents.

Public Records Hearsay Exception

While the admissibility of public records is often addressed by the statutes governing the public entities creating or maintaining those records, the admissibility of public records not covered by such specific statutes may be addressed under the old rules through the business records hearsay exception.[11] Under the new rules, a general public records exception has been created which (relevant to workers' compensation hearings) allows for the admission of records documenting the activities of a public entity, matters observed pursuant to a duty, and "factual findings resulting from an investigation made pursuant to authority granted by law," provided such findings are not deemed untrustworthy by the court.[12]

Admissions by an Agent or Employee

The old rules generally require that for the statement of an agent to be admissible, the agent must have been authorized to speak on behalf of the principal.[13] The new code requires only that the subject matter of the statement is something that an agent or employee would have known about as the result of his duties as agent or employee, and that the agent or employee made the statement during the time of the agency/employment relationship.[14] From that standpoint, the new code does not require authorization of the agent/employee statement in order for it to be admissible, so long as the above requirements are met and the necessary foundation is laid to establish the agency or employment relationship. Because the statements of a claimant's current or former co-workers are often relevant in workers' compensation case, the change in this rule is significant. While such statements may often be admissible for nonhearsay purposes or through an exception, the new rules are more likely to simply allow them as admissions.

Residual Hearsay Exception

The new code's hearsay exception based on necessity (i.e., there's no other way to get it in) requires that the admission of the statement serves the purpose of the evidence rules and the "interests of justice," as well as that the statement represents "evidence of a material fact" and is "more probative" than other available evidence.[15] The new code also adds a requirement that the opposing party be given sufficient advance notice of the intent to introduce the statement and the statement's "particulars," as well as the name and address of the declarant, such that the opposing party is given a "fair opportunity to prepare to meet it."[16]

Examination of Witnesses Generally

The rule with respect to refreshing recollection has been clarified under the new rules. When a document is used to refresh the recollection of a witness, the opposing party has the right to have the document produced, to cross-examine the witness regarding its contents, and to enter into evidence the portions of the document relating to the testimony given.[17] However, if the document is protected by attorney/client or work product privilege, it remains protected and need not be produced or admitted.[18]

With respect to cross-examination, the right to "a thorough and sifting cross-examination" as to any relevant matter is retained under the new rules.[19]

Impeachment

The "vouching rule," which generally prohibited a party from attacking the credibility of its own witness, was eliminated from the old rules by amendment in 2005.[20] The new rules continue to provide that the credibility of a witness may be attacked by any party.[21]

When a character witness is called to impeach (or rehabilitate) another witness, the old rules allow testimony only as to the other witness's general reputation for truthfulness or untruthfulness without citing specific examples.[22] Under the old rules, the character witness is prohibited from providing his or her own opinion as to the other witness's truthfulness. The new rules specifically allow the character witness to give his or her own opinion. The new rules also eliminate any potential confusion as to the scope of the reputation or opinion testimony allowed by the character witness, limiting it solely to "character for truthfulness or untruthfulness."[23]

In order to impeach a witness with a prior inconsistent statement that was not made under oath, the old rules require that counsel make the witness aware of the content of the statement and the "time, place, person, and circumstances attending" it.[24] If the statement was written, the witness must be shown the statement.[25] The new rules do not require the statement be disclosed to the witness in advance, only that the witness be "first afforded an opportunity to explain or deny" the statement before extrinsic evidence of the statement is admissible.[26]

The new rules are unchanged with respect to impeachment of a witness by evidence of criminal convictions (i.e., crime must have been punishable by death or imprisonment of one year or more, unless the crime was one of "dishonesty or making a false statement;" crimes

generally are not admissible for impeachment if more than ten years has elapsed since the date of conviction or release, whichever is later).[27]

Expert Testimony and *Daubert* Challenges

It is rare that a *Daubert* challenge pops up in the context of a workers' compensation hearing, but it does happen under the existing evidence rules. However, the rules state that the criteria for admitting expert opinions as to scientific, technical, or otherwise specialist knowledge "shall not be strictly applied in proceedings conducted pursuant to Chapter 9 of Title 34…."[28] Presumably, the relaxation of these standards is due to the Administrative Law Judge's ability to assign the appropriate weight to the testimony of a given expert. In light of this change, it appears likely that expert testimony will be allowed into evidence over a *Daubert* challenge in virtually all instances.

Conclusion

Evidentiary issues that specifically address the role of "trial judge" versus "jury" are usually irrelevant in workers' compensation hearings, where an administrative law judge acts as both as the evidentiary gatekeeper and the trier of fact. There are many changes to the evidence code which primarily affect civil jury trials or criminal trials, and those changes are not addressed by this article. Regardless, with the exception of evidentiary rules specifically addressed in the Workers' Compensation Act (such as the admissibility of medical records), the new evidence code will govern workers' compensation hearings beginning Jan. 1, 2013. As the new rules tend to allow the admission of more evidence, figuring out how to deal with that evidence once it is admitted will be a challenge for attorneys and litigants alike.

(Endnotes)

1 O.C.G.A. §§ 24-1-1—24-14-47 (Effective Jan. 1, 2013).

2 For a more comprehensive article regarding the changes to the evidence code (from which much of the information in this article was obtained), see Milich, Paul S. (2011), "Georgia's New Evidence Code: An Overview," *Georgia State University Law Review*: Vol. 28: Iss. 2, Article 3. available at: http://digitalarchive.gsu.edu/gsulr/vol28/iss2/3.

3 See, e.g., Woodruff v. Woodruff, 272 Ga. 485 (2000).

4 O.C.G.A. § 24-8-802 (Effective Jan. 1, 2013).

5 Id. § 24-8-801(d)(1)(a) (Effective Jan. 1, 2013).

6 Id. § 24-8-801(c) (Effective Jan. 1, 2013).

7 Id. § 24-8-803(1)—(3) (Effective Jan. 1, 2013).

8 See, e.g., Neill v. State, 247 Ga. App. 152 (2000).

9 O.C.G.A. § 24-8-803(6) (Effective Jan. 1, 2013).

10 O.C.G.A. § 24-8-803(6) (Effective Jan. 1, 2013).

11 O.C.G.A. § 24-3-14 (2011).

12 O.C.G.A. § 24-8-803(8) (Effective Jan. 1, 2013).

13 O.C.G.A. §10-6-64; § 24-3-33 (2011). See also, A.A.L., Inc. v. Colonial Pipeline Co., 280 Ga. App. 237 (2006) (requiring proof of agency and that the agent was "speaking within his authority").

14 O.C.G.A. § 24-8-803(d)(2)(D) (Effective Jan. 1, 2013).

15 O.C.G.A. § 24-8-807 (Effective Jan. 1, 2013).

16 Id.

17 O.C.G.A. § 24-6-612(a) (Effective Jan. 1, 2013).

18 O.C.G.A. § 24-6-612(b) (Effective Jan. 1, 2013).

19 O.C.G.A. § 24-6-611(b) Effective Jan. 1, 2013).

20 Id. § 24-9-81 (2011).

21 Id. § 24-6-607 (Effective Jan. 1, 2013).

22 O.C.G.A. §24-9-84 (2011).

23 O.C.G.A. § 24-6-608(a) (1) (Effective Jan. 1, 2013).

24 O.C.G.A. § 24-9-83 (2011).

25 Id.

26 O.C.G.A. § 24-6-613(b) (Effective Jan. 1, 2013).

27 Id. §24-6-609 (Effective Jan. 1, 2013).

28 Id. §24-7-702 (g) (Effective Jan. 1, 2013).

Comments from the Chair

By Lynn Blasingame Olmert

As the 2011-12 year approaches its end, I have had an opportunity to reflect on our workers' compensation system, in general, and the practitioners, in particular, who comprise our system. It has certainly been my good fortune to have chaired a section that has set such a high bar for professionalism and congeniality. I am proud and honored to have served as your chair, and now that my term is approaching its end, please know that I will continue to work with the section to help preserve its reputation as the best section in the Bar.

The Workers' Compensation Section has continued to serve its members in a variety of capacities. Our membership has grown, and the seeds have been planted for continued growth in the years to come. The executive committee has worked hard this year and should be applauded for their accomplishments. Members of the executive committee are Gary Kazin, John Blackmon, John Christy, Joe Stegall, Kelly Benedict, and Gregg Porter. During the 2011-12 year, we have implemented a number of projects and programs to serve section members and the workers' compensation community.

The year began with the ICLE Workers' Compensation Law Institute on St. Simon's Island in October 2011. The seminar is the largest workers' compensation event of the year and is attended by practitioners throughout the state. I was privileged to have a dedicated committee to plan and organize the seminar. Presiding over the seminar were Hon. Viola Drew of the State Board of Workers' Compensation; G. Robert Ryan of Allen Kopet & Associates; and Susan J. Sadow of Susan J. Sadow, P.C. The seminar focused on recent developments and trends in workers' compensation and on ethics and professionalism, trial practice tips, as well as significant medical issues that confront workers' compensation attorneys.

Prior to the Institute, John Christy, with the assistance of the executive committee, selected the recipient of the Distinguished Service Award. The Award is given on an annual basis to a member of the Workers' Compensation Section, who has served the workers' compensation community and helped the system to operate properly and effectively. After accepting nominations from the section, David B. Higdon (deceased) was selected as the 2011-12 recipient. The Award was presented to his family at the Institute.

Additionally, the executive committee, under the leadership of newsletter co-editors, Kelly Benedict and Gregg Porter, has kept workers' compensation practitioners updated on hot topics in the area of workers' compensation, through the publication of section newsletters. They have been instrumental in keeping members aware of significant changes in the rules, laws and regulations that govern the practice of Workers' Compensation. The articles have been written by well-respected attorneys, who always deliver excellent articles for the newsletters.

In keeping with the section goals of providing education to its members, John Blackmon organized the Workers' Compensation for the General Practitioner seminar, that took place at the State Bar on March 15, 2012, and was very popular. The speakers and writers selected for the presentations provided valuable and informative insights into the handling of workers' compensation claims for those who do not practice in the area on a routine basis.

In summary, the 2011-12 year has been a successful and busy year for the Workers' Compensation Section. I would like to thank all the section officers for all the hard work and time invested in making this a productive year. The forecast for the section is great for the 2012-13 year, as current Vice-Chair Gary Kazin, takes over as section chair. It has been my honor and pleasure to serve as chair of the section.

So… the Claim Requires a Mobility Vehicle?

By Michael Dresdner

When I first entered the field of accessible transportation in 1990 consumers as well as payers had few choices as to what was provided to a claimant. Additionally, there was little adherence to safety standards and mobility equipment dealers were literally praised for forging raw steel into useful transportation solutions and alternatives. Very few "manufactured devices" were available and if instructions were provided they contained phrases like "field modify as necessary".

A great deal has changed in 22 years. There have been improvements in how products and solutions are provided. Most devices and conversions are now precision-manufactured by high quality companies. Much has been accomplished and changed for the better, but there is still work to do. In many cases the knowledge of these changes and how to leverage that knowledge to insure the best outcome for the claimant has not kept pace. Many rehabilitation professionals in the field of workers' compensation infrequently work through the details of providing mobility vehicles or mobility equipment and therefore never become "experts".

Unlike the way mobility equipment dealers operated in 1990, we are now typically a well run enterprise resembling an auto dealership, stocking vehicles as well as equipment that can be readied in days versus months. Clean, fully accessible facilities are now the norm. In today's world vehicles as well as equipment and the installation of the equipment must meet multiple federal standards. Mobility equipment dealerships mandate that employees receive ongoing training and certification in their unique fields of expertise. Vehicles now have advanced electrical systems that require significant skill to troubleshoot and repair. Where we were once praised by payers and consumers for the rudimentary devices we cobbled together, both now have serious expectations of mobility equipment dealers and mobility vehicles in general. In many cases all parties hold us accountable to the highest standards of quality, safety and functionality. Unfortunately, in some cases, expectations are not clearly outlined or properly communicated and less than ideal outcomes occur.

The process of providing a transportation alternative to a person with a disability has become a complex task. When you merge the complexity of our products and services with the "unique cocktail" that is the workers' compensation system, sometimes the outcomes do not make sense. These mixed outcomes are what motivated me to write this article. The pressures from the workers' compensation system often force the sourcing of product through odd channels, and the end result befuddles everyone involved! It is not uncommon for three or more different parties to request a quote from a mobility equipment dealer and the party that makes the purchase is often influenced by factors that do not prioritize the claimant and keenly focus on his or her needs. For example, a request for a quote could potentially come from an insurer, a re-insurer and a managed care provider and sometimes from a local case manager or possibly an outside "consultant" -- or any combination of the five! This chaotic mix rarely yields the best outcome and it may not end up being cost effective. Controls are often sacrificed due to the multiple parties involved with their differing agendas.

Equipping a car or van for someone with a disability is unique to that individual's disability, lifestyle, and personal mobility device (wheelchair or scooter). The vehicle modification can yield positive outcomes, but there can be outcomes that just do not work or worse can cause physical problems for the user. One scenario that repeats itself often with seasoned claimants (those seeking a replacement vehicle) as they age is that the claimants mistakenly believe that they have good transfer skills and that they are not at risk for shoulder issues. They are often reluctant to let go of transferring to an automotive seat versus driving from the wheelchair. Someone has to say, "no" and clearly explain the risks. Many times, I have found myself as the one who seriously raises this issue.

The best way to avoid problems is to follow a plan, not unlike the claimant's plan for rehabilitation.

Driver Evaluation, Fitting and Training

Regardless of whether the claimant is a passenger or will be an independent driver, be certain that he/she is evaluated by a CDRS (Certified Driver Rehabilitation Specialist). The CDRS recognizes disabilities, has an awareness of the available adaptive equipment and knows the implications each has on driving or being transported. These professionals are certified by the Association of Driver Rehabilitation Specialists. If you are not familiar with those that serve your area, find a CDRS at www.aded.net. Here in the Atlanta area we have two programs that employ CDRS's as well as Occupational Therapists: the Shepherd Center Assistive Technology Program and Freedom and Mobility, a private firm. Both programs often travel to see a client. Your investment in a driver or passenger evaluation will definitely pay off. Without an evaluation you will not have a specific set of specifications to use to request quotes. Once "apples and oranges" get mixed, the process can fail.

The need for evaluating a driver may seem obvious, but why evaluate a passenger? There are a number of problems that can arise when a disabled passenger is not evaluated.

These can include safety issues, claimant fit, as well as weight issues. Designing a modification plan is varied and complex, even for a passenger.

In addition to the initial evaluation, the CDRS should meet with the claimant and the vendor at the time of the vehicle delivery to confirm the claimant's ability to use the equipment, that the vehicle is delivered as promised and that all the equipment operates properly and safely. If the vehicle is to be driven independently, the CDRS would confirm the placement of all driving controls (fitting), work with the mobility equipment dealer to make final adjustments and then drive with the claimant. Additional training over an extended period of time could be required depending on the complexity of the equipment or the type and severity of the disability. It is recommended that a representative from the payer be present at the delivery of a mobility vehicle or mobility equipment installation as well to gauge the mood of the claimant and make sure everything is coming together as planned.

The sourcing of mobility equipment has been complicated by many factors. In addition to the many types of solutions and typical mix of parties involved in a claim there is now……

The Internet

The Internet is an option we all use to source just about everything. It is wonderful for researching and exploring options. Most vans purchased on-line are used vans and buying the right used van can sometimes save money and get the job done. Buying a good used accessible van on the Internet might be possible if you know precisely what you are doing. In truth, on line shopping is not a simple task. In addition to the complexity of the many adapted vehicle options to consider and understand, there is also the risk of a questionable on-line purchase. Most salvaged title vehicles, flood vehicles and "less than optimal condition" vehicles end up on-line. Although improvements in databases have been made, "Title Washing", the practice of registering a salvage or flood vehicle that may have a "branded title" in a state with lax oversight and coming away with a clean title, is not uncommon. Hidden rust and mechanical problems abound. Buying on line from a dealer who does not provide local service is a risky business. The Internet seller (direct seller with no local service facility) often loses interest in you and your claimant's needs right after the check is cashed.

Although there are new vehicles sold on-line by direct sellers, that practice has slowed due to mobility dealer agreements. With the advent of the mobility auto dealership model, all mobility equipment dealers who represent a major supplier of wheelchair accessible conversion vans have signed dealer agreements with their suppliers. These agreements, amongst other covenants, state that if you sell outside of a prescribed geographic area, an area generally deemed to be reasonable for the consumer to travel to receive service, you must provide the consumers with a point of service in the areas where they live. There is often substantial need for service after the sale, and most mobility equipment dealers are not excited to adopt consumers and their needs when the retail sale was made elsewhere.

The Number of Mobility Solutions

Going back to 1990 when I started in the mobility industry there were two tracks for mobility solutions. 1) The disabled individual who could not transfer into a car and had to enter and exit a van seated on his or her personal mobility device. In this case the individual received a full sized van (like a plumber's van but with creature comforts) and various modifications were made to that vehicle to make it accessible. 2) The individual could transfer into a car and would receive a scooter or wheelchair hoist to load his or her unoccupied wheelchair or scooter, also referred to as a personal mobility device, into a car or van.

The choices now are many and the differences in these choices are significant both from a cost standpoint as well as a functional standpoint.

Lowered Floor Minivan

The popularity of the lowered floor minivan and its distribution model is the single biggest change in available transportation options we have seen in the past two decades. The lowered floor minivan concept has

dramatically altered vehicle modification, vehicle safety, and how vans are sold to an end user. Lowered floor minivans are now the vehicle of choice for most individuals who need to enter a vehicle seated on their personal mobility device. Fuel economy and drivability, including ease of operation, parking options (virtually all parking decks are now accessible to lowered floor minivans) as well as lower maintenance and insurance costs have driven this change. Users also like the fact that at a glance their van does not look like a modified vehicle. These vans are available in both side entry and rear entry models in both fully automatic and manual operation.

There are several manufactures of mobility conversions that perform modifications to allow a Dodge, Chrysler, Toyota or Honda minivan to become wheelchair accessible. The up-fit is substantial and requires that all OEM models ("Original Equipment Manufacturer) that are modified be re-submitted for crash testing as the original testing is no longer valid. These modified vans must, by law, continue to meet or exceed Federal Motor Vehicle safety Standards (FMVSS) after modification. Engineering documentation should be available upon request. Each brand of van has different interior dimensions, different features and is suitable for a slightly different modification. Not all modified vans are appropriate for all disabled users.

The options become mind boggling when you consider the depth of the lowered floor, what floor is appropriate for the height of your client, ramp width, in-floor ramp or fold out ramp, interior dimensions, weight capacity, and side entry or rear entry. Furthermore, there are differences in vehicle structure from one year to the next. For example, a 2010 and older model lowered floor Toyota Sienna is different in both door entry height and interior space than a 2011 and newer model. This dynamic occurs with all OEM models as new models are introduced. Specifications change and those specifications can spell success or failure for the claimant.

Cargo carrying capacity

Weight capacity or "cargo carrying capacity" is a critical measure. Many powered wheelchairs weigh 250-300 pounds or more. Add the occupant who is commonly 200-250 pounds and the wheelchair and occupant alone can total 550 pounds. I have personally worked with clients with a combined weight of over 750 pounds. Also, we need to take into account that an individual confined to a wheelchair may experience weight gain over time. Popular brands of wheelchair accessible minivans have cargo carrying capacities ranging from 920 pounds to over 1,400 pounds. Subtract the 550 pound combined weight of the individual and his wheelchair from the 920 pound cargo carrying capacity, the total capacity remaining is 370 pounds for all other occupants and their cargo. This number is not practical considering that five able-bodied passengers may still be accommodated plus the wheelchair and occupant. Be aware that Federal regulations do not require a mobility manufacturer or a mobility equipment dealer to document or use the weight of the wheelchair or occupant when determining cargo carry capacity. Federal rules do not recognize the wheelchair as a "seating position" and therefore documentation of actual cargo carrying capacity for a wheelchair accessible van is often not discussed accurately. An overloaded vehicle is not only dangerous (and in some cases illegal) but it is likely to experience a greater number of mechanical failures and require more frequent repair.

So although the development of all these models of lowered floor minivans has been exciting for the user, the process keeps getting more complex with more options. A keen knowledge of all these "moving parts" is required to make an educated decision and purchase. That knowledge is generally gained through a solid working relationship between the CDRS and your local mobility equipment dealer.

More options

The following is a partial list of available vehicle and equipment options for disabled drivers and passengers:

- Lowered floor minivans available with 10" to 14" lowered floors
- Lowered floor minivans available with side entry ramps or rear entry ramps, in-floor or fold-out ramp operation in both manual and automatic models

- Full-sized vans, still a viable option for larger claimants or certain lifestyle needs, are available with 6" and 9" lowered floors on ½ ton, ¾ ton and 1 ton vans both standard length and extended length
- Raised roofs and raised doors to be used in conjunction with and without a lowered floor on a full-sized van
- Interior wheelchair lifts and Under Vehicle Lifts (UVL)
- Lowered floor full-sized pick-up trucks for persons with active lifestyles who need to enter a vehicle seated on their mobility device
- Scooter and wheelchair lifting devices for unoccupied use
- Newly introduced trailer-lifts for small cars and SUV's allowing almost any car of any size to transport a personal mobility device
- Turning automotive seats to assist in transfer and entry/exit to a car or van
- Robot 2000 which after the user transfers into the vehicle will pick up your manual wheelchair at the driver or passenger door and "robotically" place it in the trunk of the car or back of an SUV
- A wide variety of column mount, floor mount and electronic hand controls
- Low effort electronic gas/brake and steering controls
- A wide variety of manual, retractable and powered wheelchair restraints

Government involvement

The prohibition to make inoperative final ruling was issued by the federal government in early 2001. This was the first rule issued that substantially changed the mobility industries' behavior in regards to federal compliance. The rule allows a mobility equipment dealer to alter (make inoperative) certain safety features if the alteration is required for a person with a disability to be transported in or to drive a motor vehicle. This ruling was a good idea that was long overdue. Vehicles simply cannot be cost effectively manufactured where all aspects of operation are safety-tested to meet the needs of every person with a disability. There are simply too many options. The "make inoperative" is now used in some fashion in most cases where a vehicle is modified for a person with a disability. In order to take advantage of the "make inoperative" the mobility equipment dealer must register with NHTSA (National Highway Traffic Safety Administration) and become knowledgeable in how to use and apply the rule. Once registered, the dealer is also obligated to follow other administrative components of the rule too. One component of the rule includes informing every consumer in writing if in the process of modification the dealer has reduced the vehicle's cargo carrying capacity by 250 pounds or more, not including the wheelchair and occupant. With minor exceptions, each vehicle modified must be weighed. The addition of the weight of the wheelchair and occupant and a look at true cargo carry capacity is a verbal conversation that ethical dealers engage in with the consumer. In addition to many other requirements, the dealer must also label the vehicle certifying compliance. There are many other little-known government regulations that mobility equipment dealers must follow in order to be compliant with state and federal law.

Industry standards

Like most industries, the mobility industry has an industry group. It is called the National Mobility Equipment Dealers Association (NMEDA). NMEDA became a national organization in 1991 and has grown to a powerful institution within the mobility industry. Virtually every well-qualified mobility equipment dealer is a NMEDA QAP member. Highlights of what NMEDA offers and by extension what a NMEDA QAP Dealer (participates in the NMEDA Quality Assurance Program) offers a consumer include the following:

Adherence to national guidelines that dictate everything from accessibility of a dealership facility to how a vehicle shall be modified including compliance with all FMVSS as well as SAE (Society of Automotive Engineers) standards. NMEDA accredited dealers must be insured and carry a minimum of $1,000,000 in product liability coverage.

NMEDA operates a quality assurance program that requires site inspection for all participants and monitors compliance with NMEDA guidelines, FMVSS as well as strict adherence to proper record keeping.

NMEDA provides a mediation panel for consumers who feel that a NMEDA member has not fully met their responsibilities in a transaction or in the event of repeated and unresolved issues.

Doing business with a local NMEDA dealer will assure that you are getting access to the best products provided through an efficient retail delivery channel and that your vehicle and/or equipment will be compliant and installed in compliance with all industry, state and federal requirements.

NMEDA dealers generally represent a wide array of products and manufacturers assuring that you get choices and are not steered towards a single product or concept. New and used vehicles are available at most locations.

Local Brick and Mortar NMEDA QAP dealers

The local NMEDA QAP dealer has been, and always will be, the best way to meet the needs of the injured worker. If the worker is properly evaluated and that prescription is provided to the mobility equipment dealer, he or she will be provided the product that is needed. You can also rest assured that there will be service after the sale and that the claimant will be taken care of every time he or she needs support. That support comes 24/7/365. There is a nationwide network of NMEDA QAP dealers to support your claimant if he or she travels or relocates. Most NMEDA QAP dealers are also members of the Adaptive Driving Alliance (ADA) and have reciprocal service agreements for anyone traveling who has a mechanical need.

The injured worker faces a daunting amount of issues when going through the rehabilitation process. One of the significant milestones in this process is to once again own a vehicle that works for their needs post-injury. The independence that a modified vehicle provides is elixir to someone who has been unable to move about freely. Imagine the disappointment that comes with a failed or problematic purchase. Hopes are dashed and tempers can flare. The best assurance of a successful vehicle or equipment buying experience with minimal hassle is to first have the claimant evaluated by a CDRS and then make a purchase through a local NMEDA accredited QAP mobility equipment dealer.

Mobility Works is certified to perform a one-hour "lunch and learn" course on mobility vehicles and equipment. Credit hours for case managers as well as occupational therapists can be earned.

Michael Dresdner is the Director of Customer Care for Mobility Works and was previously the owner and president of HDS VANS & MOBILITY. HDS VANS was acquired by Mobility Works in March 2012. Mobility works operates 20 retail mobility equipment dealerships in the Southeast, Mid-West and California. Dresdner can be reached at Michael.dresdner@mobilityworks.com.

Fictional New Accident vs. Change in Condition - Is The Debate Really Over Yet?

By Ela Orenstein

For many workers, whether or not an aggravation of a previous work-injury is characterized as a fictional new accident or a change in condition dictates whether or not that worker is entitled to future indemnity benefits. If a disabling aggravation is characterized as a change in condition two years after a worker has last received benefits, it will be argued that the two year statute of limitations contained in O.C.G.A § 104(b) is a bar to future indemnity benefits. However, if the disabling aggravation is instead characterized as a fictional new accident, the worker may be entitled to additional income benefits. Despite the severity of the consequences of each characterization, the distinction has long been unclear and there has been a good deal of confusion as to which factors are dispositive in the analysis. In fact, two recent cases, decided by the Court of Appeals only seem to muddy the waters.

In *R.R. Donnelley et al. v. Ogletree*, 312 Ga. App. 475, (2011), the Court determined that the injured worker had sustained a fictional new accident based on the fact that after returning to work, Ogletree performed light duty work that exceeded his physical restrictions, thereafter experiencing a gradual worsening of his condition, resulting in disability. The *Ogletree* Court distinguished a change in condition to occur "when the claimant's disability results from his performance of 'usual,' 'normal,' or 'ordinary' work duties. In contrast, a 'new accident' occurs when there is the intervention of new circumstances imposed upon the claimant." Id. at 479 (citing C*ertain v. U.S. Fidelity & Guaranty Co.*, 153 Ga. App. 571, 573 (1980). Because Ogletree returned to work performing under new circumstances, the Court found he sustained a new accident as opposed to a change in condition. Id. The fact that Ogletree previously received indemnity benefits in excess of two years prior to the fictional new accident date did not prove dispositive in the Court's analysis.

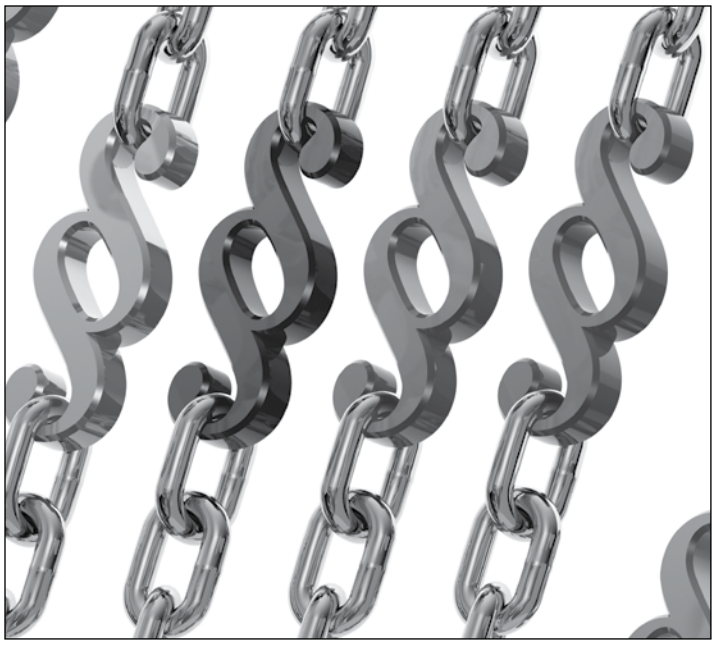
On the other hand, in *Shaw Industries, Inc. v. Scott*, 310 Ga. App. 750 (2011), under a similar set of facts, the Court of Appeals found the injured worker to have suffered a change in condition, and further found Scott's claim for indemnity benefits was time-barred under O.C.G.A § 34-9-104(b). In *Scott*, the Court of Appeals seemed to center the analysis on whether or not the injured worker had previously received indemnity benefits. Relying on Central State Hospital v. James, 147 Ga.App. 308, 309–10 (1978), the Scott Court explained the distinction between a change in condition and a new accident:

> [w]hen a claimant sustains an injury, *is awarded compensation*, returns to his ordinary job duties, but then as a result of the wear and tear of ordinary life and the activity connected with performing his normal duties, his condition gradually deteriorates to where he cannot continue to perform his ordinary work, such facts constitute a change in condition and not a new accident. On the other hand, when a claimant is injured on the job but continues, *without an agreement or award*, to perform the duties of his employment until forced to cease work because of a gradual worsening of his condition that is at least partly attributable to his physical activity in continuing to work, such facts constitute a new accident.310 Ga.App. 752-53 (internal citations omitted) (emphasis added).

The *Scott* Court indicated that if a worker has previously received indemnity benefits, any worsening of their injury is necessarily a change in condition (and thus subject to the two year statute of limitations). While the *Ogletree* Court also referred to the circumstances discussed in the often cited, *Central State Hospital v. James* case, the *Ogletree* Court further noted that "the situations described in James, were not meant to be exclusive." 312 Ga. App. 479.

It is well settled that the purpose behind the State's workers' compensation law is a humanitarian one. And in fact, the notion of the "fictional new accident" was crafted to avoid punishing injured workers for returning to work after an injury. Injured employees who do return to work should have confidence that they will not be without any means of securing disability income if their condition should worsen as a result. See *Footstar, Inc. v. Liberty Mut. Ins. Co.*, 281 Ga. 448 (2006). An injured worker that has never received income benefits, but has experienced a gradual worsening of a previous work injury is entitled to argue they have experienced a fictional new accident and if disabled from work, may recover income benefits. However, according to the Court of Appeals reasoning in Scott, if that very same worker was paid one week of disability benefits and the aggravation is more than two years from the last date benefits were received, that worker is prohibited from claiming a fictional new accident.

The Court of Appeals in *Scott* seemed persuaded that *Central State Hospital v. James*, 147 Ga. App. 308, (1978), *Laurens County Bd. of Educ. v. Dewberry*, 296 Ga. App. 204 (2009), (and other cases cited in *Scott*) establish that fictional new accidents cannot, as a matter of law, arise when an injured worker has previously received disability benefits. However, I think this conclusion is inconsistent with the case law and an erroneous extrapolation of the principle that a change in condition may only arise when there has been previous payment of disability benefits. This principle simply does not establish, as matter of law, that in all cases where there has been a previous payment of disability benefits there can only be a finding of a change in condition.



Naturally, the Scott decision came as a heavy blow to the injured worker in that case, and when the Supreme Court of Georgia agreed to review the case, attorneys on both sides of the bar seemed enthusiastic at the prospect of additional clarity being cast on the question of which factors prove dispositive in the analyses of whether an accident should be characterized as a fictional new accident or a change in condition.

Ultimately, the Supreme Court did affirm the *Scott* decision, though in doing so did not track the analysis of the Court of Appeals decision in Scott, but instead emphasized whether or not the gradual worsening of Scott's injury was linked to more strenuous work duties, similar to the Court's analysis in *R.R. Donnelley et al. v. Ogletree*. *Shaw Industries, Inc. v. Scott*, No. S11G1815 (July 2, 2012). In deciding that Scott had undergone a change in condition in lieu of a fictional new accident, the Court noted that when Scott returned to work, she returned to a position that was far less strenuous and experienced a gradual worsening of her condition "as a result of the wear and tear of ordinary life." Id. In its decision, the Supreme Court went on to distinguish *Ogletree* where the worker returned to a more strenuous position. Id. In so discussing *Ogletree*, the Supreme Court adopted the reasoning contained in the Court of Appeals decision in *Ogletree*.

In light of the fact that the Supreme Court upheld the reasoning contained in *Ogletree* it seems that the issue of whether or not a worker has previously received benefits is not dispositive in the analysis of whether or not an aggravation of a pre-existing condition is characterized as a change in condition or a fictional new accident. This result fits more squarely with purpose of the act by not penalizing workers who return to work after receiving indemnity benefits. Further, this analysis honors the very definition of "injury" contained in Georgia Code section 34-9-1(4) which includes "the aggravation of a preexisting condition by accident arising out of and in the course of employment."

Chairman's Corner

By Richard Thompson

Greetings from the Georgia Board of Workers' Compensation. The 2012 Session of the Georgia General Assembly recently ended and a few revisions to the Workers' Compensation Act were adopted by the General Assembly. House Bill 971 now awaits Gov. Deal's signature. First, revision of OCGA §34-9-15 will now allow the Board's settlement unit to require "Hartman" language to be incorporated in settlement documents if the Board or any party to the settlement agreement requires such language. Second, OCGA §34-9-221 will be amended to allow the Board to excuse non-payment of a settlement after a showing by the employer that due to conditions beyond the control of the employer the income benefits cannot be paid within the period prescribed. OCGA §34-9-226, relating to the appointment of a conservator, will be amended to increase the threshold amount for settlement approval by the Board from $50,000 to no more than $100,000. Finally, the hearing loss statute, 34-OCGA §34-9-264, has been amended to add another level at which hearing loss attributable to the workplace can be detected.

In the continuing effort to expedite the resolution of issues in compensable cases, our administrative law judges will now assist the parties, via a conference call, to work out matters which should not require an evidentiary hearing. The details of the "Expedited Resolution" process are set forth fully on the SBWC website.

There has been a personnel change in the Settlement Division with the recent resignation of Frances Finegan. In her place, long time mediator, David Kay and his new assistant, Lindsey Pence, have stepped into the void left by Frances' absence; they will continue to maintain a goal of approving close to 90 percent of all stipulations and agreements within 10 days of receipt at the SBWC. Often times, the stipulations and agreements are being approved on the same day of submission.

The Annual Regional Seminar Series has recently concluded. This year's stops, which were well attended by HR managers and others in the Workers' Comp industry, included Newnan, Macon, Lawrenceville and Savannah. Finally, the Board's Annual Education Seminar will once again take place at the Renaissance Waverly Hotel in Marietta, Georgia. The dates for this year's seminar are Aug. 27 – 29.

ICMS2 Update

By Pam Carter

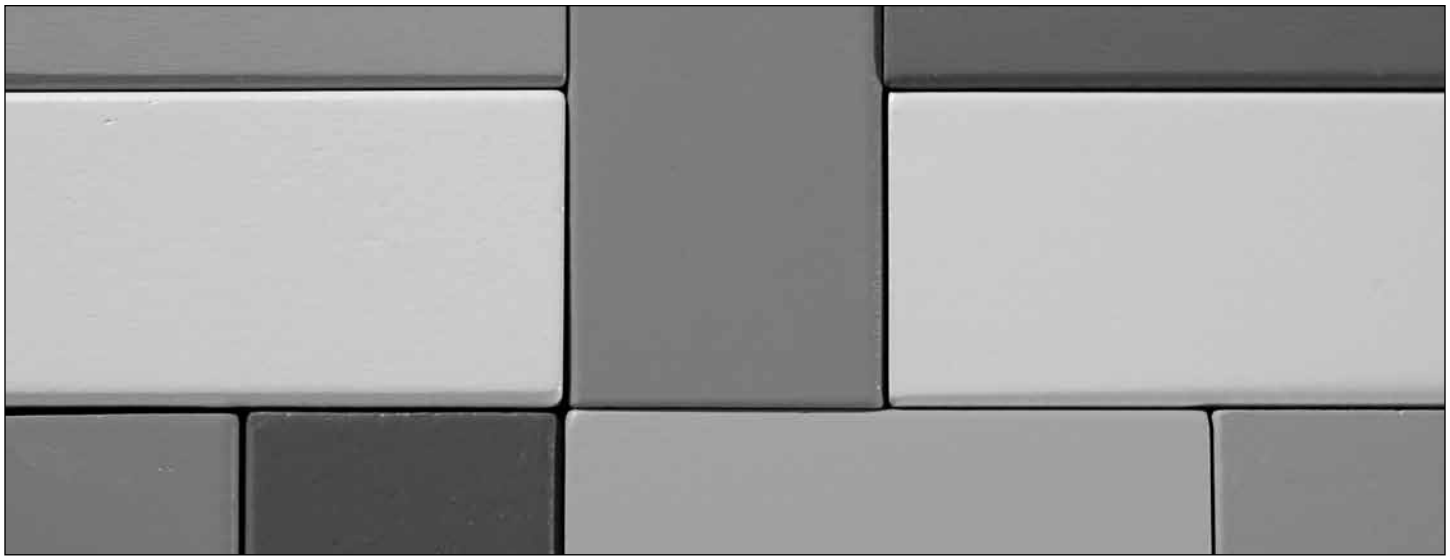
The work effort for the State Board of Workers' Compensation software/hardware upgrades is nearly two years old (July 2012), and like most two year olds, the Integrated Claims Management System II (ICMS2) has displayed some unique traits, like being one of the first applications hosted in the state's newly created ICE (Integrated Computing Environment) located at the North Atlanta Data Center (NADC). SBWC, like other government agencies across the nation, is in an ongoing ever changing battle to protect their systems and data. This new environment is extremely important as Georgia state government systems experience as many as 15 million probes per day from those looking for holes in our security. ICMS2 leverages all of the advanced security protocols of the NADC ICE environment, and implements advanced data encryption and authentication for protecting claims related data. The secure data center and enhanced security features of ICMS2 will minimize the Board's risk of penalties that result in the event of data loss or unauthorized access to claim files.

And just like all two year olds, ICMS2 likes to be independent. So, the Board made another strategic business decision to take ownership of ICMS2 by bringing application development in-house. This decision enhances the Board's ability to rapidly address ever changing business demands more cost efficiently and effectively. At two years old, ICMS2 has developed an expected case of "mine" in identifying the right personnel for this upgrade project, and our existing IT team has been expanded to include additional staff with different skill sets. After a year of working with the staff at SBWC as the ICMS2 Project Manager, Ron Lee was welcomed on board as the Chief Information Officer in February. In this new role Ron is directing the design and construction of ICMS2 and the movement of the ICMS2 application into the state's secure data center. Ron brings with him experience and expertise in both project management and application development. Also new on staff are three developers and a business analyst who will assist the existing IT staff in implementing ICMS2.

A great deal of the work in these two years has been devoted to exploring ways to extend ICMS into a feature rich ICMS2 that will meet the needs of additional users in the workers' compensation community and will improve the existing service. In addition to the workers' compensation attorneys, ICMS2 will grant access to rehab suppliers (file-only access), insurance carriers (group funds, and self insured employers included) and third party administrators who are licensed with SBWC. The new users will be registered and trained to use ICMS2/WCONLINE, and all users will be supported through the SBWC Call Center. The new users will be phased in over time to ensure an orderly expansion of online access.

ICMS2 will stay close to the sound building blocks of ICMS/WCONLINE to improve the external users' interface to the data that is captured at SBWC in claims files. In addition, documents and forms will be easily viewable no matter the browser, and once again will be presented in the customary format for ease of use. EDI transactions in ICMS2 will truly be "transparent" to the end user as we build familiar SBWC forms from the data provided in the transactions. The new ICMS2/WCONLINE will provide a direct interface for emailing filed documents to other parties to the claim in compliance with service of process requirements.

This fall ICMS2 will begin to welcome old and new users to a state of the art claims application designed to provide an easy to use tool for the stakeholders in the Georgia workers' compensation program. We are looking forward to introducing our "new baby" to you.



Medicare Set-Asides: Identifying and Fixing Common Problems in the Allocation Process

By Benjamin A. Leonard, Bovis, Kyle & Burch, LLC

The Medicare Secondary Payer Act ("MSP") was created in 1980 by the Omnibus Reconciliation Act, and has been amended several times since then. The goal of the legislation was to prevent the shifting of financial responsibility for medical care from the primary payer or insurance carrier to Medicare. Under the MSP, the Center for Medicare and Medicaid Services (CMS) has the right to disregard a settlement and seek reimbursement for medical expenses paid by Medicare for which another primary carrier (i.e., workers' compensation) would be responsible. See 42 USC§1395y (b)(3)(A). CMS has also been statutorily empowered to seek reimbursement from the plaintiff/claimant and the attorneys involved. 42 CFR §411.26. MSP was never really enforced by the government until the late 1990's. According to the Government Accounting Office (the "GAO" – you know, the guys that threw that great bash in Las Vegas a while back…) from 1991 until 1998 alone CMS paid for nearly $40 billion in medical care for workers' compensation claims that should have been paid by carriers or parties to the claim. Thus, the recovery incentive was, and still is, high for the federal government.

Confronted with insolvency of the Medicare trust fund in 2024, over the last 10 years, the Department of the Treasury has provided the Department of Health and Human Services a steadily increasing budget to assist with enforcement of the MSP. Thereafter began the widespread use of the Medicare Set-Aside ("MSA") trust, a vehicle which allows the insurer to close its medical files by depositing an estimated amount of money into the hands of the claimant (or an administrator) for future medical care in order to avoid making Medicare the primary payer for medical care that is rightly the responsibility of an insurance carrier. The trust also allows the claimant to settle his or her claim and control his or her own medical care directly. The money for the claimant's use is deposited into an account for direct payment to the medical provider, however, the money can only be used for medical care, not discretionary funds for the claimant.

Most of us who have been practicing over the last 10 years, during which time CMS has gone from laissez-faire to a pit-bull in terms of enforcement, have seen a number of vendors emerge offering services ranging from Allocation services, rated age estimates, annuity quotes/sales, and third-party administration. The quality of their services tends to vary widely and without predictability - as does the accuracy of their advice. The rise of these companies comes in the wake of a considerable amount of fear in the legal community over CMS enforcement of the MSP, and the lack of consistent answers from CMS, via the Department of Health and Human Services pertaining to enforcement powers statutorily granted to it.

There are few areas where both insurance and claimants' attorneys can claim to have a vested interest in being on the proverbial "same page". The MSA Allocation process is one of them. The parties must always consider Medicare's interests in claims where Medicare could become or currently is a payer, primary or secondary, in the claim. Submission to and approval by CMS must be done in most instances. For claimants' attorneys, making sure the medical allocations are accurate means the claimant's allocation will be used judiciously and only for items related to the accident/injury. For insurance defense counsel, making sure there isn't an over-allocation of the compensable conditions is key to keeping costs contained. In both instances, problems arising during the Allocation submission/approval process can derail settlement of the claim, and can create issues if the Allocation is approved by CMS, if the Allocation is inaccurate, or if the Allocation assumes conditions not previously treated as compensable.

All the attorneys in the claim should carefully review all the MSA documents and become engaged in the process. In other words, while allowing the vendor (if one is used) to handle the MSA is usually the preferred method, often it is unwise. Very few vendors are licensed attorneys (usually they are medical professionals or financial professionals) and they are not culpable parties in the process – i.e. – CMS will not pursue them for reimbursement as they will the employer, the insurer, the self-insurer, the attorney(s) involved, and, perhaps worst of all, the injured worker. We all have a vested interest in protecting ourselves and our clients from a poorly prepared MSA by being engaged in the process. While a multiple volume set could be drafted on the problems currently pending with CMS enforcement and consistency, what will follow is a thumbnail sketch of "red flags" to look for in reviewing Allocations prior to submission to CMS, and how to avert a potential catastrophe.

The Cover Letter and Related Attachments to CMS

CMS requires certain information be included in a cover letter with the submission package for the MSA. Many initial mistakes are made with this document, which will cause rejection by CMS before the actual projection is examined. Often inaccurate, incomplete, or a lack of the required information will lead to mistakes, or at the very least, a rejection of the submission package. A concise statement and history of the injury and resulting medical care is necessary. A similar statement of concurrent, but unrelated, medical conditions for which the claimant is

being treated should also be included. It is ***very*** important for any claimant's counsel to review this information in the document. Medicare is ***increasingly*** rejecting payments for non-related conditions in an increasing manner due to inaccurate information in these letters (i.e., refusing to pay for a kidney treatment when the injury was to the lungs due to a vague reference to "internal trauma). For defense counsel, care should be given to what conditions are included in the MSA so that a large conditional payment demand from CMS(per 42 CFR § 411.47 CMS can demand payment for prior Medicare payments made for conditions it finds to be work related) is not tendered after the Allocation is approved. For example, any potential appeal of what is and is not related during a conditional payment demand may be deemed void if you submit an Allocation which includes the conditions you are appealing. The preparation of this document accurately and completely sets the tone for the Allocation submission process.

Potential problems to look for:

- Failure to include the complete settlement amount of the claim including the MSA amount.
- Inaccurate or no descriptions of the injury or injuries, including the date(s) upon which the injury or injuries occurred
- Failure to include the codes, especially an ICD-9 diagnosis code, for the injury or injuries
- Inaccurate diagnosis code(s) for the injury or injuries
- Failure to indicate whether the claimant is currently enrolled in Part A and Part B of Medicare, or only Part A
- Failure to include accurate contact information for all the parties to the claim, including the employer and counsel for each party.
- Failure to include the release from the claimant (CMS release).

Tips:

- ALWAYS ask for and review the cover letter and submission materials by the submitter.
- All parties should be communicating regularly at this point in the process in order to insure all information is accurate and complete.
- The claimant and his/her attorney should get the release to the Allocator as soon as possible.
- The claimant and his attorney should perform a cursory review of the description of the injury or injuries for accuracy. If possible, a review of the ICD-9 codes should be compared to any bills or medical records in the file.
- Make sure the settlement amounts and MSA Allocation amounts are accurate in the cover letter.
- If any party or parties move, change information, etc. that should be conveyed to the Allocator prior to submission.

Pharmaceutical and Medical Costs

As we all know, medical costs, especially pharmaceutical costs, have escalated exponentially over the last 10 years, far outstripping the cost of living increases during the same time, Medicare bases its acceptance of a proposed Allocation on the costs of medical procedures on the fee schedule of the state of venue for the MSA; if the claimant moves to another state during the pendency of the Allocation approval, care must be made that the Allocation will not be exhausted due to a price difference from state to state.

In calculating prescription medication costs, the Average Wholesale Pricing ("AWP") method is employed by CMS. This, in turn is based upon the RED BOOK, a compendium of medicine prices across the country which takes the aggregate of these prices for Allocation approvals. In its April 3, 2009, memorandum, and again in its June 1, 2009, memorandum, CMS addressed the problem of inconsistent methodologies in allocating drug costs by mandating the use of RED BOOK Drug References in evaluating the sufficiency of drug charges in allocations. Submitters need to include "reasonably probable and predictable" future drug recommendation, even if the claimant is not currently receiving these medications. Tapering of drug usage requires affirmative evidence from the treating physician that this is probable, as well as medical evidence of current tapering.

CMS will not accept less expensive medication substitutes unless actually ordered by a physician, nor will it give consideration to price reductions as brand name medications become generic (i.e., the patent runs out on the medication in the future). CMS also requires medications to be identified by their name, National Code, form, strength, frequency and price per unit. This allows CMS to easily verify pricing used in MSA reports. CMS does state that

MSA report submitters are "encouraged to present any evidence they believe is helpful" and that nothing in these specific medication pricing guidelines should discourage this principle Nonetheless, it should be emphasized that the strength of the evidence in favor of lower pricing, tapering, and dosage will be weighed carefully by CMS.

The submitting allocator will and must include CPT (Current Procedure Technology) codes, ICD-9 coding (relates to the type of work injury) and HCPCS coding (Healthcare Common Procedure Coding System) for all medical procedures. NDC (National Drug Code) directory codes should be used for all medications. The Allocation should state, clearly, that all costs paid are under the appropriate state fee schedule rather than at "actual cost" (i.e., what the doctor charges outside the fee schedule). A few states do not have fee schedules (Delaware, Indiana, Iowa, Missouri, New Hampshire, New Jersey, Virginia and Wisconsin). Fee scheduling should not be suggested where it does not exist, and hence medical costs may outstrip an Allocation funding.

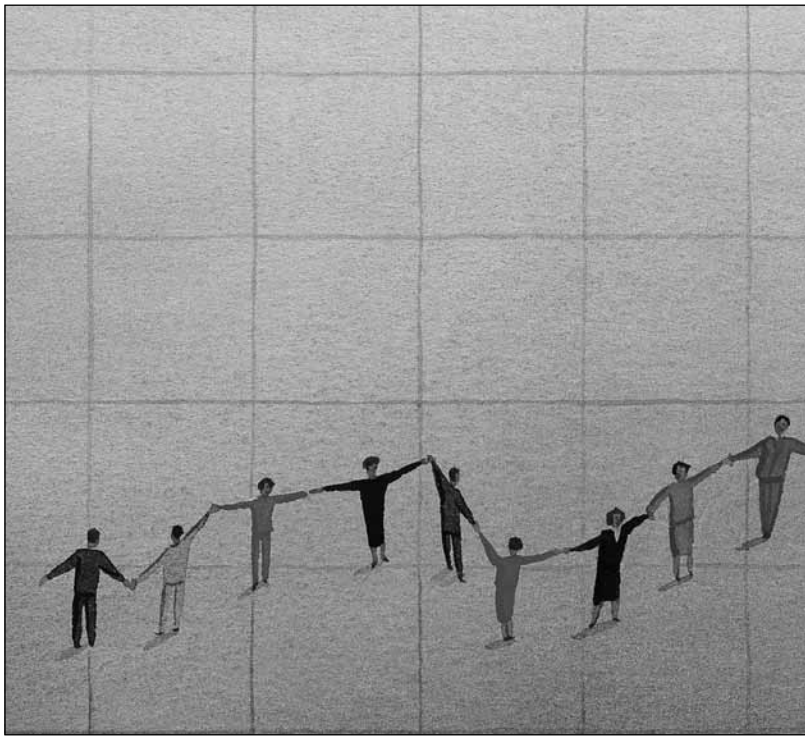
One last note is the calculation of so called "seed" money when an Allocation is annuitized (usually in bigger MSAs – i.e., over $50,000.00). CMS defines "seed" money as consisting of the first two (2) years of medical costs, including prescriptions, plus the fee scheduled cost (if it can be fee scheduled) of the first surgical procedure (if one is projected) in the Allocation. Failure to properly calculate and explain the amount of the seed money will open up the Allocation to having pricing done outside the state fee schedule for medical procedures, which can be costly.

Potential problems to look for:

- The allocator did not use RED BOOK pricing, but rather, used secondary vendor pricing (Wal-Mart, Target, etc.).
- The claimant has not reached MMI yet, which will likely mean CMS will increase the projections.
- Prescriptions and treatments have not been prescribed by a treating physician, making the Allocation inaccurate in the eyes of CMS.
- Inadequate documentation for "tapering" of drug usage by the treating physician, which frees up CMS to use its own projections.
- Reliance upon Utilization Review or IME reports rather than medical documentation by a treating physician in compiling future medication and medical needs.
- Incorrect or incomplete dosages, intake frequency, and NDC coding by the allocator for the medications
- Failure to include an adequate prescription drug payment history
- Failure to use a state mandated fee schedule rather than full, actual charges for medical care
- Failure to use the coding mentioned above
- Proposed prescription drug amount is not clearly delineated in the proposed allocation.
- Seed money is inadequately projected or explained in Allocation.
- Reliance upon a generic drug being developed when it does not yet exist.
- Failure to have a physician prescribe generic medications

Tips:

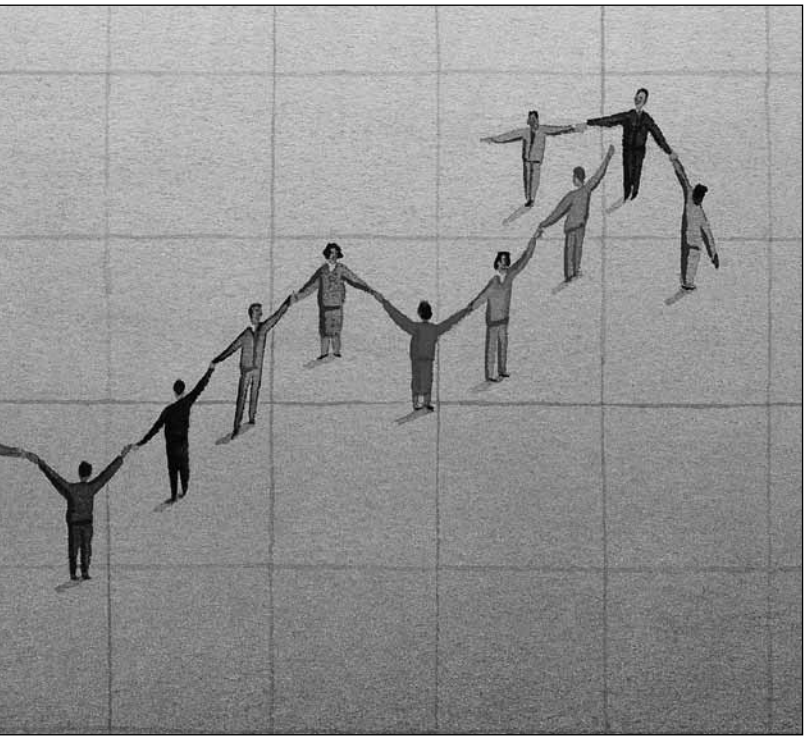
- Have all parties meet with the authorized treating physician, or treating physician, in order to obtain a future treatment plan for accurate allocations. Ideally this is done at the time MMI is achieved, or post-settlement. Make certain the physician understands the nature of the meeting, and that the process is non-adversarial but rather for the good of the patient in determining, accurately, future care needs. Have him or her review the Allocation if it has already been prepared
- When expensive medications are in the allocation costs, check to see when the patents for the medications expire. Medications are generally only manufactured by one company, thus, the price is fixed (and usually quite high) until the patent on the medication expires. Thereafter, any manufacturer can produce the medication, and the result is almost always a huge drop in the medication costs. Sometimes waiting a year or more to submit the Allocation and set up the MSA can result in a huge net savings if the patent on an expensive medication



will expire in the near future, opening it up to generic competition.

- Utilization Review ("UR") is a preferred method of cost review by many carriers wherein they have nurses and other experts employed by the carrier review the costs as opposed to having an opinion from an expert outside the carrier. CMS will allow submission of UR reports in the Allocation process, however, the weight assigned to this documentation is not very high even in non-compensable claims. It should be noted that in many states using this process is illegal for claims handling in general.
- Double check all dosages, intake information and coding in the Allocation (a treating or authorized treating physician can do this); errors in this area can be very costly to any or all of the parties. Off-label drugs should be avoided whenever possible as their costs will not be governed by RED BOOK.
- If the injury occurred less than 2 years from the date of the submission, the prescription drug payment history should include those payments made since the date of accident; if more than 2 years has occurred, the last 2 years of payments prior to submission should be included.
- Review the medication payment ledgers for accuracy.
- Make sure all calculation methods are identified and are accurate for medical needs.

Use of Life Expectancy/Rated Ages, Third Party Administrators, Reversionary Language and Annuities



A profitable cottage industry of rated age and annuity allocators has sprung up in the last 10 years as a sub-set of the Medicare Set-Aside Allocation vendor community. Often these vendors are owned and operated by the Allocation vendors themselves, and are merely operated under a different name for liability purposes. Rated age calculations are statistical methods of comparing an individual's medical histories with the long term mortality and survival rates which could impact life expectancy. The calculation of rated ages is more of an art form than a science, despite the construction of complex actuarial tables for their preparation. It should be underscored at this point that the rated age is a tool to calculate annuity costs. A rated age estimate is not, nor has it ever been, an accurate gauge of how long a person will live. CMS will allow the use of a rated age to calculate an Allocation, however, it must conform to CMS standards (use of the mandatory language, on the proper letterhead, and no submission of conflicting quotes). If multiple rated ages are submitted, they will use the median rated age. If the parties submit a rated age quote that does not conform to their standards, CMS will use the CDC life table to calculate the Allocation which will very likely result in a huge increase in the Allocation amount.

Annuities can be useful in high dollar MSAs; after all, the pay the value of future medical costs at present day costs. Unfortunately, sometimes in the rush to push the product, many vendors are selling annuity products that are of little if any savings to those who purchase them if the settlement amounts are low (usually $50.000.00 or less does not yield significant savings). Annuities can offer some protection for all the parties and should be considered when possible. For the claimant, if funds are used for expenses unrelated to the work injury, he or she will only be penalized (by Medicare denying medical care) for the annuity year when the payout occurs. It also makes the claimant assume some financial discipline for the money (i.e., he or she cannot spend all the money all at once). For the claimant's counsel, it is less money to handle at the end of the settlement process to be transferred in and out of a trust fund. For the employer/insurer/self-insurer, it provides a cost savings over the life of the medical expenses that can be significant. However, if the annuity funding company misses a payment, goes insolvent, or there is a problem otherwise with disbursement, there is almost always a provision in the settlement documents that places the responsibility upon the employer/insurer/self-insurer to assume responsibility for the annuitized payments.

It has become trendy for some Allocators (mostly those who also provide annuities) to suggest reversionary language for the settlement documents granting a right to the remaining corpus of the MSA trust to the payer (insurer or self-insured usually) upon the death of the claimant if he or she does not exhaust the trust. Some self-insureds do this on a regular basis. I strongly suggest avoiding this language to anyone and everyone who will listen for several reasons. First, the State Board of Georgia

(or any other judicial body overseeing the settlement approval) may or may not approve its use depending on the wording. Also, it may conflict with other provisions of the settlement documents. Moreover, the language may not be (and usually is not) prepared by an attorney. After all, would you want your legal license used by a non-attorney to practice law? Further, and more importantly for self-insured employers and insurers, the use of reversionary language potentially assigns some risk of liability to them if the MSA trust is not managed properly. Since they have a financial interest, albeit a contingent one, in the remaining funds upon the death of the claimant, CMS may look to them to recoup funds improperly used if an accounting of the trust reveals such misuse. Finally, the self-insured, the insurer, and/or the employer must look at potential tax liabilities for the return of the contingent funds with a right of reverter – this is a risk that may or may not be welcomed by their shareholders (if publicly held), to say the least, due to the unpredictability of the situation.

Potential problems to look for:

- Failure to use the ***mandated*** language by CMS when submitting rated age information
- Annuities issued by a company which does not have a proven track record of financial stability, or which "outsources" annuities to companies after the quote is provided
- Allocation based on a rated age issued by an annuity company which is related to or owned by the insurer (a life insurance company, for example) – the rated age will be rejected entirely by CMS is this is the situation.
- Use of an annuity in lower value MSAs (under $50,000.00).
- The entire payout amount of the annuity is not included in the submission (should be in the cover letter).
- Annuity payments directly to the claimant without designation – these can be considered income by the Internal Revenue Service as constructive receipt of income.
- Ambiguous (or, really, any) reversionary language granting the insurer and/or employer the right to money left in the corpus of the MSA trust upon the death of the claimant.
- Failure to designate a specific administrator, even if it is the claimant, for the administration of the MSA.

Tips:

- Make sure the ***exact*** following language is in the rated age statement from any submitter:

  "Our organization certifies that all rated ages obtained on the claimant, at any time during that individual claimant's lifetime, have been included as part of this submission to the Centers for Medicare & Medicaid Services"

- Per the CMS Memorandum dated May 14, 2010, the failure to include this language will result in the Allocation submission being rejected.
- Review any and all rated ages used in the allocation process. CMS mandates that all independent rated ages are submitted on letterhead from an insurance carrier or settlement broker (per the CMS Memorandum dated May 14, 2010).
- Do not use more than one rated age in the submission – otherwise CMS will use the median rated age in calculating the MSA.
- Stay away from the use of reversionary language; its use can continue to bind the self-insured or insurer to the MSA should a problem occur with the Allocation funds post-approval; if the funding of the MSA becomes an issue, the self-insured/insurer potentially has a remaining financial interest in the Allocation with the reversionary right to remaining funds in the corpus upon the death of the claimant, thus CMS could add them as a party to any claim for Allocation mismanagement.
- Do some homework on the annuity company to make sure they are not actually an annuity broker – there are significant commissions for annuities, and they remain high for annuity issuers who do not have a proven track record (i.e., they may or may not be financially responsible!). The annuity company failure to pay timely can, and will, result in the obligation reverting back to the employer/insurer/self-insurer.

Conclusion

Many attorneys are apprehensive about MSAs, and rightly so. Much of this fear comes from a lack of working knowledge about their makeup and also from bad information garnered along the way from a variety of sources. CMS has further complicated the situation by applying their enforcement policies unevenly, and contradicting themselves repeatedly in webinar-type town hall meetings held occasionally for interested parties.

The MSA becomes an issue at, on, or after the settlement of the underlying claim. At that point, we the attorneys must put aside the adversarial nature of the claim, and work together to protect the participants in the process. Each of us should assume an affirmative obligation, even if it is cursory in nature, to review the fundamental information in the Allocation submission, and coordinate with the other counsel involved. Doing so will save a lot of time, effort, and potential issues for ourselves, and our clients.

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